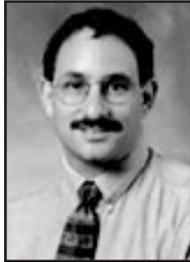




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## PRESIDENT'S MESSAGE

### Texas Medical Board Blows Its Big Chance

Howard Blumstein, MD FAAEM

They blew it. They had a great opportunity in their hands, and they screwed up. It sounds harsh, but it is true. They failed the public they are supposed to serve. I believe they buckled under pressure and made a bad decision that will reverberate for a long time.

I am writing, of course, about board certification. In case you missed it, here is a brief rundown: until very recently, the Texas Medical Board (TMB) had a rule governing who could advertise themselves as "board certified." A physician needed to be certified by one of the two mainstream organizations, the ABMS (which includes ABEM) or the Board of Osteopathic Specialists (includes AOBEM). One could be certified by an alternative board and advertise them self as board certified if that alternative board met a series of requirements. Included in those requirements was "...identifiable and substantial training in the specialty or subspecialty area of medicine..." under consideration. (TAC §164.4.b.5)

The BCEM (Board of Certification in Emergency Medicine) is an alternative board. It is part of the American Board of Physician Specialists (ABPS). It does not require specialty specific training, but rather accepts physicians with training in a variety of other specialties including family medicine, internal medicine, anesthesia and surgery. According to a verbal statement from TMB executive director, Mari Robinson, a physician trained in family medicine requested an opinion from the TMB as to whether his BCEM certification met the board's advertising criteria. The administrative staff decided affirmatively without consulting the board, and the ABPS trumpeted this "recognition" on its website.

Then came a series of hearings, statements against acceptance of BCEM by a variety of EM societies including AAEM, ACEP, AOBEM and SAEM, statements in favor of recognition by representatives of ABPS, and pressure in the form of a small herd of lawyers, plus a sound guy and a videographer attending at least one hearing and all representing ABPS. A subcommittee was appointed to address the issue.

And then...the board blinked. The subcommittee came up with a rule that changes the educational requirements from those above to: "...substantially equivalent to the

requirements of the ABMS or the BOS existing at the time of application to the medical board." This is totally appropriate. It ties the alternate boards' educational requirements to the mainstream boards. It recognizes the reality that appropriate training can and will change with time. But they also threw in this zinger: "A physician who holds a certification that was granted prior to September 1, 2010, and whose certifying board was approved by the medical board for advertising purposes prior to September 1, 2010, is considered to meet the requirements of subsection (b) of this section."

To the best of my knowledge, BCEM is the only board that might be covered by this loophole. It seems clear that this was inserted specifically for BCEM. Dr. Pat Crocker, the only emergency doctor on the TMB and a member of the subcommittee, hailed the decision in EMNews, saying "I think it was the most Solomon-like solution we could find."

*The purpose of the board is to protect the public's safety and welfare through the regulation of the practice of medicine.* That's what the Texas statutes say about the TMB. *Safeguarding the public through professional accountability* is the board's motto on its website. There isn't anything about finding compromise positions and certainly nothing about playing Solomon.

How can they create a rule that says all boards have to meet established training standards, but then carve out a special exception for a single board? It can't be done logically unless you say that emergency medicine is less important to public safety than other specialties. I don't believe that was the case.

The TMB came under a great deal of pressure from the ABPS to accept BCEM. I think the TMB failed to stand up to that pressure.

Here is the bottom line: the TMB failed its duty to look out for the Texas public's interests and safety. The silver lining is that any other state board can adopt the same rules without needing to create the special exemption for BCEM. I suppose, on balance, it is a win for AAEM and its well-established belief that properly board certified emergency docs are best prepared to serve the public. But it is a loss for the Texas public.

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## Editor's Letter

David D. Vega, MD FFAEM

### The "Other" Corporate Practice of Medicine

AAEM stands strongly against the corporate practice of medicine. Former AAEM president Robert McNamara wrote, "The Corporate Practice of Medicine (CPOM) occurs when a for-profit business entity exerts control over the practice of medicine. CPOM presents a major problem for the specialty of emergency medicine, and for you, the practitioner."<sup>1</sup> Most often, CPOM is discussed in the context of corporate management groups that attempt to control physicians and their care of patients. However, there are other types of business entities that attempt to exert control over the practice of medicine. Pharmaceutical manufacturers continue to increase their efforts to influence the way that physicians practice medicine. Of particular concern is the influence that drug manufacturers have in the development of specific treatment guidelines related to their products.

Consider the issue of using tPA as a treatment for ischemic stroke. The American Heart Association (AHA) Guidelines for the Early Management of Adults With Ischemic Stroke<sup>2</sup> list tPA as a Class I recommendation, the highest possible rating, for the treatment of ischemic stroke. A colleague of mine recently shared a quote from a neurologist who noted, after reading AAEM's position statement on tPA for stroke, that he was surprised that there is still concern over the use of tPA after the elevation of its recommendation by the AHA. So, why is there still controversy?

Unfortunately, there remains question about how corporate support may have influenced the recommendations to use tPA in acute stroke. Genentech is the U.S. producer of tPA. Internationally, the drug is distributed by Boehringer Ingelheim. The disclosures of the AHA Stroke Guideline writing group<sup>3</sup> show that these companies (and a lot of other pharmaceutical manufacturers) have very good representation. We should not assume that any individual knowingly

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#### AAEM Mission Statement

The American Academy of Emergency Medicine (AAEM) is the specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine, and to ensure a high quality of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

#### Membership Information

Fellow and Full Voting Member: \$365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)

\*Associate Member: \$250

Emeritus Member: \$250 (Must be 65 years old and a full voting member in good standing for 3 years)

Affiliate Member: \$365 (Non-voting status; must have been, but are no longer ABEM or AOBEM certified in EM)

International Member: \$150 (Non-voting status)

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\*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program.

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made decisions to support tPA based on corporate influence. However, the ability to make completely unbiased decisions about a drug's effectiveness may be impaired if one is sponsored in any way by the very company that makes that drug.

Most readers of this editorial are probably not surprised to hear that both Genentech and Boehringer Ingelheim also contribute directly to the AHA and its affiliates. According to the American Heart Association, 27.9% of the organization's revenue in 2008-2009 (most recent data available) comes from corporations.<sup>4</sup> The AHA's National Center (not counting affiliate and local offices) received over \$17 million in 2008-2009 from pharmaceutical companies and device manufacturers, including Genentech and Boehringer Ingelheim. According to financial documents from the AHA, these two companies alone contributed almost \$3.5 million to the AHA National Center from 2004 to 2009.<sup>5</sup>

If the medical community were even close to having a consensus opinion about the use of tPA in acute ischemic stroke, the financial support of these companies *might* be less of a concern. However, there remains a great divide between supporters and opponents of this drug. It appears that individuals who have any sort of association with the manufacturer usually interpret the evidence to say that tPA's benefits far outweigh its risks. Many others who are not associated with the company interpret the very same evidence much differently, stating that at the very best, the benefits of tPA are minimal compared to the risks. With such diverging opinions over this treatment, why was tPA given a Class I designation, implying that there is "general agreement that the procedure or treatment is useful and effective"<sup>6</sup>? It would seem that tPA deserves, at best, a Class II designation: "Conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment." One must be at least a little concerned that some of the difference in opinions might be due to corporate influence. It is unlikely that physicians knowingly make decisions to support tPA based solely on corporate influence. However, the subconscious effects of corporate influence should not be underestimated.

I am not suggesting the AHA is a bad organization or that all of their recommendations should be abandoned. The organization sponsors very good research and public education about issues like heart disease, smoking cessation, obesity and a lot more. However, providers should not just assume that recommendations from any organization are free of influence from corporate interests. There are many examples of organizations that make recommendations where drug company influence is in question. As a specialty and as individual providers, we have the responsibility to weigh the evidence in as unbiased a manner as possible and present patients with appropriate therapeutic options.

Unfortunately, most clinicians just do not have the time to go through all of the evidence surrounding every controversial topic in medicine. Thus, we rely on experts and guidelines to help give us an idea of what treatments the evidence best supports. If these experts and guidelines are influenced by pharmaceutical companies, though, are we truly providing the best care when following their advice?

With an issue as important as stroke and a treatment option that has a fairly high risk of death, we must make every effort to know what the studies really show and not what the pharmaceutical industry would want us to know. Most of us are aware of the NINDS<sup>7</sup> and ECASS<sup>8</sup> studies, as these are frequently cited by both sides of the issue, albeit interpreted very differently. How many of us have the

same level of familiarity with the other trials that do not show benefit to tPA or that show increased morbidity and mortality with tPA? Recently, a *Wall Street Journal* Health Blog article<sup>9</sup> highlighted an interesting website, "the NNT."<sup>10</sup> Under the topic of thrombolytics for stroke, this site summarizes 11 different trials of tPA for stroke. Four of the listed trials are noted to have been stopped early due to mortality and/or a lack of benefit. Five additional trials are noted to show no benefit. I am not endorsing this website or necessarily supporting all of its conclusions. Rather, I use this as an example to further illustrate the divergence of opinions that exist and encourage clinicians to review the evidence for themselves, rather than rely on any one source of recommendations.

Pharmaceutical companies attempt to influence our practice of medicine from many different angles. Direct-to-consumer advertising, political lobbying, and physician detailing all ultimately impact the way we care for patients. Corporations exist to make money. They would not invest so heavily in these activities if they did not see significant increases in the use of their drugs and, in turn, profits. We must always be watchful for any kind of corporate attempt to exert control over the practice of medicine so that we may maintain the integrity of the physician-patient relationship.

*My opinions in this editorial are not going to be shared by all. If you feel strongly about any aspect of the information contained herein, please share your thoughts by sending an email to [cseditor@aaem.org](mailto:cseditor@aaem.org). Your comments may be featured in an upcoming issue of Common Sense.*

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# Current Studies Focus on Access to Emergency Care and Medical Malpractice

Kathleen Ream  
Director of Government Affairs

According to a recent study by the RAND Corp, approximately 28% of emergency department (ED) visits were first contact for a new health concern that could have been provided at an alternative site. In the past, general practitioners were considered the providers of first contact in the United States. The authors<sup>1</sup> found that today only 42% of the 354 million annual visits for treatment of a new health problem are made at the office of a patient's primary care provider. The rest of the visits are made to EDs (28%), specialists (20%), and outpatient care departments (7%).

This study further found that time of day had an influence on the site of care. As one might expect, more than 95% of acute-care, office-based primary care providers and specialist visits occurred on weekdays. Also, outpatient care departments received 89% of their acute care visits on a weekday. EDs, due to the availability of 24-hour access, saw 30% of their acute care visits on weekends. On weekdays, after standard office hours, EDs saw 37% of acute care visits.

Timely access to primary care is a continuing problem in this country. In 2009, 28% of Medicare beneficiaries and a similar number of privately insured individuals had difficulty finding a primary care provider. This suggests that individuals, out of necessity, will continue to seek primary care in a different setting than a primary provider's office.

Another recent study<sup>2</sup> explored the potential use of urgent care centers and retail clinics to decrease ED acute care visits. While care at these sites does not help to address the issue of continuity of care that is lost by a patient's use of the ED and these less conventional sites, use of these alternate care sites could realistically reduce the numbers of non-urgent primary care visits seen in EDs. The authors report that 27% of ED visits could be seen in these sites. This would include care for sore throat, sinus infection, pink eye, ankle sprain and simple fractures. Urgent care centers and retail clinics are viewed by patients as more convenient as well as saving money for the patient and payer.

Medical liability reform is an important topic that was not addressed in the **Patient Protection and Affordable Care Act**. Health care reform will have the effect of extending health care benefits to more individuals; the ability to decrease the national cost for health care is an important concern. One area that is identified for national health care cost reductions is medical liability reform.

In a study entitled "National Costs of the Medical Liability System," the authors analyzed the components cost of the medical liability system.<sup>3</sup> The overall costs, including defensive medicine, were found to be an estimated \$55.6 billion in 2008, representing 2.4% of total national health care spending. The study concluded that while medical liability is unlikely to "bend the health care cost curve significantly," it may be important for other reasons. While liability reform represents a very small part of national health care costs, it is still a significant amount of "real" money. In another study<sup>4</sup> that was released recently, the authors addressed the fear of litigation that drives providers to practice defensive medicine. The study found that defensive medicine practices were widespread within almost all clinical areas and in 28 out of 35 physician specialties.

Policymakers and regulators will be forced to deal with many issues during the implementation of health care reform. With the expansion of coverage, more individuals will move from the uninsured to the insured category and begin to seek services. The question is how will we deal with access and how can we move medical liability reform.

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## Summary Judgment Granted in Claim of Emotional Distress

On July 16, 2010, the U.S. District Court for the Northern District of California granted a medical center's motion for summary judgment in a suit alleging emotional distress damages from a denial of treatment at the medical center's ED resulting in an EMTALA violation (Pugh v. Doctors Medical Center, N.D. Cal., No. 08-4159, 7/16/10).

### The Facts

On February 19, 2008, Tommie Pugh, accompanied by his wife, Willia Pugh, sought emergency medical care from the Doctors Medical Center's (DMC) ED, in Oakland, California. Pugh was immediately assessed by a triage nurse. Pugh complained of burning from the knees down and stated that he had diabetic neuropathy. He told staff to "hurry up," because he wanted pain medication.

Pugh was then examined by Malcolm Johnson, MD, a contract employee hired by California Emergency Physicians. Johnson reported in the record that the patient "was argumentative and noncompliant" and that Pugh reported a history of hypertension, diabetes and high cholesterol. While Pugh complained that he could not move his right lower or upper extremities, Johnson noted that the patient had walked into the room without difficulty and that he also used his right hand and arm to remove EKG leads from his chest. Johnson did not find on physical examination or by observation that Pugh was having right-sided or lower extremity weakness. Johnson noted in the chart that all Pugh said he wanted was methadone.

Johnson reported that Pugh "became upset when he was informed that methadone was not available in the ED. At that point, Mr. Pugh got up from the table and told Dr. Johnson that he wanted to leave. Dr. Johnson tried to keep Mr. Pugh from leaving, but...Mr. Pugh signed a form verifying that he was leaving against medical advice."

The Pughs returned to their home where Tommie Pugh took his methadone. "Mr. Pugh testified in his deposition that after he drank the methadone, he 'blacked out,' and that he had no recollection of any events that occurred during the next few weeks – until 'a month or so later when I came to.'" Because Tommie Pugh was feeling weakness in his right side and Willia believed Tommie was having a stroke, she drove her husband back to DMC. Upon arriving at the

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medical center, Willia Pugh asked two ambulance attendants sitting outside the ED entrance for assistance in getting her husband inside.

Dr. Johnson came outside. According to Willia Pugh, “she told Dr. Johnson that Mr. Pugh was ready to come back to the hospital, but Dr. Johnson told her that he...was tired of their ‘shucking and jiving and lying,’ and...allegedly threatened to have the Pughs arrested for trespassing if they did not leave the hospital area.” Johnson stated that “he took three or four steps out of the ED entrance toward the Pughs’ vehicle, but did not approach the van, or see who was in it. He concedes having spoken with Mrs. Pugh, but maintains that Mrs. Pugh did not want or request care or treatment...Johnson denies that he ever argued with Mrs. Pugh or that he refused to treat Mr. Pugh.”

Willia Pugh took Tommie to another facility, Alta Bates, located 25-30 minutes away from DMC. Medical records indicate that upon evaluation in the Alta Bates’s ED, Tommie Pugh “was alert, awake, and oriented...a CT scan of his head showed a 2.4 cm left thalamic and basal ganglia hemorrhage with some mild edema. A neurological evaluation concluded that no surgical intervention was required.” Tommie Pugh was admitted to the ICU for further treatment, and two weeks later, Pugh was transferred to another facility for subacute treatment.

On September 3, 2008, the Pughs filed suit with a claim of negligence per se against DMC, based on a violation of EMTALA, and a claim of intentional infliction of emotional distress against Johnson. On December 16, 2009, both defendants filed motions for summary judgment. In March 2010, the federal district court denied Johnson’s motion as to the intentional infliction of emotional distress claim, but for the negligence per se claim against DMC, the court granted the motion insofar as “Mr. Pugh was seeking damages based on physical injuries, and denied it insofar as he was seeking damages

for emotional distress...the court also noted that the pleading of the EMTALA claim as a claim of negligence per se was problematic, as an EMTALA violation does not give rise to a negligence claim, and Mr. Pugh had alleged no other viable underlying claim of negligence” (57 HCDR, 3/26/10).

In a second amended complaint, Tommie Pugh stated a cause of action against DMC for a violation of EMTALA, and as a result of the EMTALA violation, alleged a claim seeking emotional distress damages. DMC sought summary judgment on the EMTALA claim.

### The Ruling

The court wrote that under EMTALA, a plaintiff can recover “those damages available for personal injury under the law of the state in which the hospital is located...In California, where a plaintiff seeks damages for violation of a statutory duty, the general rule of tort damages – that all detriment proximately caused by a breach of a duty is compensable – applies...in order to recover damages for emotional distress where there is no physical injury, the injury suffered must be “severe” – that is, substantial or enduring, as distinguished from trivial or transitory.”

The court then determined that “plaintiffs lack sufficient evidence to raise a triable issue with regard to whether Tommie Pugh suffered severe emotional distress as a result of DMC’s alleged violation of EMTALA.” Moreover, finding no support for plaintiffs’ position that “severe emotional distress can be inferred from an EMTALA violation absent any direct evidence that plaintiff actually suffered emotional distress,” the court granted the motion for summary judgment. However, the court also added that Willia Pugh’s claim against Johnson for intentional infliction of emotional distress remained in this case.

## View from the Fishbowl

Joel M. Schofer, MD RDMS FAAEM

Member, AAEM Board of Directors

Lieutenant Commander, Medical Corps, US Navy

Emergency Ultrasound Director, Emergency Department

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I’m floating around the Persian Gulf, alternating between stints on the USS Pearl Harbor and USS Dubuque. During my most recent stay on the Dubuque, or “the Dub” as we affectionately call it, I had a roommate who is a “GMO” or General Medical Officer. He has completed his internship and is now serving as a primary care physician for a battalion of Marines while he tries to figure out what residency he wants to pursue.

Part of his role as a GMO...actually the majority of his role as a GMO...is to listen to young Marines complain about various musculoskeletal aches and pains associated with what they call “PT” or physical training. PT consists of lifting weights, running, doing CrossFit, Marine Corps Martial Arts Program or “McMAP” training, and all other things that involve perspiration and just being a Marine. The inevitable knee, ankle, back and shoulder pain is usually met with the same simple prescription: a Motrin, more trips to the water fountain and more PT.

There is nothing wrong with a Marine that cannot be cured by Motrin, a full canteen, more PT or any combination of these. Nothing.

I remember him relating to me one day that he had become less empathetic to the musculoskeletal complaints of his Marines due to the constant stream of orthopedic injuries.

I frequently encounter a similar attitude in the ED when a patient presents for something deemed “nonurgent” by the ED resident or provider seeing the patient. It is usually a 2 a.m. fever in a child, a patient with a “cold” or some other true non-emergency. I imagine all of us think these things from time to time.

Well, as luck would have it, guess who hurt his back doing PT? Deadlifting did him in.

He didn’t look too bad the first day. There was a definitive loss of mobility and a slight limp.

“Oh, I just hurt my back deadlifting. No big deal.”

“Did you take any Motrin?”

“No, I don’t think I need it.”

The next day he couldn’t get out of his bed. Granted, this was no normal bed. We call them “coffin racks” (beds on a ship are called racks) because the fit for anyone over 5’10” tall is tight, coffin-like. If you are about 6’3” or taller and have any upper body strength, you have no ability to even roll without dislocating a shoulder. He is 6’2”, and we’ve already established he does PT, so moving in a coffin rack

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# AAEM Opposes Flawed Reimbursement Provisions in the Health Care Reform Bill

Mark Reiter, MD MBA FAAEM, AAEM Secretary/Treasurer  
Craig Norquist, MD FAAEM

Earlier this year, AAEM opposed the passage of the Patient Protections and Affordable Care Act (PPACA) noting significant flaws to the wide ranging health insurance reform bill, including its failure to include adequate tort reform provisions. Another ramification of the PPACA, outlined in an interim final rule, sets insurer compensation rates for out-of-network providers of emergency services. The Academy believes these provisions may lead to substantial harm to our emergency departments and the patients that we serve. In October 2010, the AAEM board of directors passed the following position statement and communicated our concerns to the Department of Health and Human Services.

## American Academy of Emergency Medicine Position Statement

### Emergency Services Reimbursement Provisions in the Patient Protections and Affordable Care Act (PPACA)

The American Academy of Emergency Medicine opposes the emergency services reimbursement provisions outlined in the interim final rule of the Patient Protections and Affordable Care Act (PPACA) that sets insurer compensation rates for out-of-network providers of emergency services. Emergency departments (EDs) play an integral role in our health care system. In addition to treating urgent and emergency conditions, our emergency services providers act as a safety net for the significant portion of the population who are uninsured and underinsured or do not have access to a physician. Between 1996 and 2006, ED visits rose by 25%, while the number of EDs fell by 10%, as many EDs could no longer afford to remain operational. At the same time, emergency departments are uniquely bound and targeted by the unfunded federal mandate, Emergency Medical Treatment and Labor Act (EMTALA), to treat anyone who seeks emergency services, regardless of their ability to pay. Payments from government sources alone are already insufficient to cover costs or expenses and continue to be threatened by measures such as the Sustained Growth Rate (SGR). Commercial and private insurers unequivocally provide the critical funding of emergency care by allowing cost shifting to pay for the emergent care of uninsured and underinsured patients mandated by federal law. This cost shifting mechanism is crucial in maintaining the viability of our nation's emergency departments.

The Patient Protection and Affordable Care Act attempted to prevent insurers from treating their customers differently depending on their use of a contracted versus non-contracted emergency departments. What it has done, in effect, is create an incentive for health insurance providers to create an artificially low rate of payment using the PPACA's flawed methodologies. PPACA 45 CFR 147.138(b)(3) (i) sets out-of-network emergency service reimbursement rates at the greatest of: (1) the median amount negotiated with in-network providers for the same services, (2) the Medicare rate, (3) the amount calculated by the same method the plan generally uses to determine payment to out of network providers. The first two options describe deeply discounted rates that will force drastic cuts in emergency department care and result in emergency department closures. The last option allows an insurer to manipulate their out of network rates using flawed databases such as Ingenix. Again, this would result in cuts and closures. 45 CFR 147.138(b)(3)(i) essentially gives insurers every incentive to avoid forming adequate networks that include emergency care services and to circumvent good faith negotiations for emergency services reimbursement, since the default result would be significantly discounted rates for out of network emergency care.

Under PPACA 45 CFR 147.138(b)(3)(i), the nation's emergency departments may be unable to continue to provide free and deeply discounted care to our most needy citizens. It could force closures of emergency departments that are already operating on the edge of insolvency. 45 CFR 147.138(b)(3)(i) is a boon to insurers, who will become more profitable by no longer contracting with emergency departments and instead paying the default lower rates. But in doing so, it will hinder our society's ability to provide emergency care and will hurt the general public. Our nation's medical safety net will be irreparably harmed; emergency departments will be forced to make further cuts, and the pace of emergency department closures will escalate.

AAEM feels strongly that the provisions within 45 CFR 147.138(b)(3)(i) should be withdrawn. Alternatively, they should be modified or regulated in such a manner that commercial insurers are obliged to negotiate payment for emergency care in good faith, without simply depending on the PPACA to set an artificially low default rate.

## Delaware Valley Chapter

**More than 125** emergency medicine residents attended the 7th Annual Meeting of the Delaware Valley Chapter of AAEM (DVAAEM). They heard a panel discussion on "Reality Emergency Medicine: Patient Satisfaction, Liability Issues, Hospital Politics and Other Survival Tips." Discussants included Anthony Mazzerelli, MD JD FAAEM, Tom Rebbecchi, MD FAAEM, and Dom Colletta, MD FAAEM (pictured to the right). Other speakers included AAEM president, Howard Blumstein, MD FAAEM, and editor of *Academic Emergency Medicine*, David Cone, MD FAAEM.





## American Academy of Emergency Medicine

FOR IMMEDIATE RELEASE  
November 22, 2010

Contact: Kay Whalen (kwhalen@aaem.org)  
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MILWAUKEE – The American Academy of Emergency Medicine releases the following position statement regarding EMTALA mandated emergency care.

### Position Statement: Definition of Negligence for EMTALA-Mandated Emergency Care

The American Academy of Emergency Medicine (hereinafter AAEM or the Academy) supports an increased level of scienter for EMTALA mandated care.[1] Specifically, AAEM supports state laws that require plaintiffs to prove gross negligence or recklessness, by clear and convincing evidence, in cases alleging negligence for emergency department care, and for subsequent care to stabilize emergency medical conditions.[2]

Within the setting of an ongoing liability crisis in the United States, this change in the burden of proof will address current threats to the viability of emergency medical care. Approximately 15% of all emergency departments in the U.S. closed in the past 20 years. Hospitals face an increased difficulty in maintaining on-call physicians in vitally important specialties. Subsequently, many emergency departments must now pay physicians to assume on-call responsibilities, a relatively recent phenomenon.

Moreover, emergency departments, emergency physicians, and on-call specialists disproportionately bear the burden of EMTALA's unfunded mandate. Approximately 20-25% of emergency department patients currently have no health insurance and do not pay for their emergency care. The recent Health Care Reform legislation signed into law will diminish this, but the economic burden of EMTALA will continue to be borne by emergency departments and providers. This is due to the payment disparities caused by a disproportionately high number of underfunded patients that seek care in emergency departments under the purview of EMTALA, which requires provision of an appropriate medical screening examination and stabilizing treatment, but provides no payment under this mandate. This EMTALA mandate, along with the heightened risk of caring for acutely ill patients with whom the physicians have no prior relationship has resulted in the closure of emergency departments and a growing scarcity of physician specialists to provide stabilizing care. Physicians must often practice defensively in this setting, significantly increasing the cost of health care.

Therefore, the Academy supports recent legislative activity in states requiring plaintiffs to prove gross negligence or recklessness, by clear and convincing evidence, in cases alleging negligence for emergency department care, and for subsequent care to stabilize emergency medical conditions. This will help reverse the trends of emergency department closures, the scarcity of physicians to assume on-call responsibilities, and the excesses of defensive medical practice.

[1] Emergency Medical Treatment and Active Labor Act 42 U.S.C. §1395dd

[2] See, e.g.: Georgia OCGA §51-1-29.5 (2009)

###

The American Academy of Emergency Medicine (AAEM) is the specialty society in emergency medicine today. As an organization, AAEM believes achievement of board certification represents the only acceptable method of attaining recognition as a specialist in emergency medicine.

For more information, please visit [www.aaem.org](http://www.aaem.org)  
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James S. Walker, DO FAAEM	Robert A. Wetherbee, MD FAAEM	Andrea L. Wolff, MD FAAEM	Michael F. Zorko, MD FAAEM
Steven M. Walkotte, MD FAAEM	Kay Whalen	Samuel Woo, MD FAAEM	
	Ellen W. White, MD FAAEM		

View from the Fishbowl - continued from page 5

is going to be difficult, if not impossible, for him. Add some back pain and spasm, and you need a crowbar and a four-man working party to get him out of it.

Once the working party was done removing him from his bed, he found he couldn't bend over to tie his boots and could barely do so when seated. Later that day after gimping around the ship, he gave in and entered a 48 hour Flexeril-induced coma.

"This really hurts. I can barely move! My sympathy for all those guys coming to sick call for back pain just went up."

This reminded me of my own enlightening medical illness. It was a Sunday in a single-coverage ED on a Japanese island with one military hospital. All of the ED beds were full, and I was busy. Mostly due to a steady diet of Coke Zero and Arizona sweet tea, I developed right flank pain. Initially, it was just really, really sore. I was just sitting there wondering what I had done to myself and worrying more about the guy in the isolation room who I was sure had meningitis and needed an LP.

About 10 minutes later, I was brought to my knees vomiting in the staff bathroom. The charge nurse saw me as I left the bathroom and told me I was the same color as my scrubs, which were green. I told her my symptoms.

"You have a kidney stone! Get in the crash bed. It's the only one we have left."

Before I knew it, I was in the crash bed 2 mg deep into Dilaudid, with a Toradol and Zofran chaser. My director was on the way in to cover the shift.

Just to add insult to injury, I noticed when I was putting on my gown, a humbling experience itself, that my right testicle was hurting and was retracted. It looked like it was trying to burrow its way back from whence it came.

I remember thinking to myself, "Is this all referred pain from a torsion?" Then I realized that the only urologist on the entire island was on vacation.

My wife's a pediatrician, and I remember showing her my "concerning finding" and asking her, "Is that normal? Does it normally look like that?"

"I don't know. How would I know?"

"You look at it too! What's it normally look like!?"

To summarize, in about a half hour, I had gone from working a busy single-coverage shift to wondering if something was wrong with my "junk," as the Marines like to call it.

I don't think anyone ever in the history of the world has hoped and prayed as much as I had that a kidney stone would be visible on a CT scan. The alternative, a testicular torsion without an available urologist, was not something I wanted to consider.

Thanks be to God! I had a 2 mm stone at my right ureterovesicular junction with some mild hydroureter. By this time I was 4 mg deep into Dilaudid, 16 mg into Zofran, I was still in pain and vomiting, and Family Practice was writing my admission orders.

Then came the sharp suprapubic pain. I was hoping that meant the stone had passed and not that my bladder had exploded. Five minutes later, my pain was gone, and my admission orders were cancelled. Four hours later, I was at home urinating through a strainer when something that looked like two pieces of small, black dirt came out. I caught them, sent them to the lab, and they were calcium oxalate.

Thank God men do not have to give birth, because I was incapacitated, required 4 mg of Dilaudid, and almost got admitted for a 2 mm piece of dirt.

In the end, both of these stories should remind us all that even though the patient in the ED (or military sick call) is there with a "non-urgent" complaint, they are there because they are sick, in pain, have no idea what is really going on with their child, need Motrin and water for their back strain, or think their testicle is ischemic on an island with no urologist. They probably just want some help or reassurance, and it is our job to give it to them without complaining about the "urgency" of their complaints.

(Contact Dr. Schofer with any comments at [jschofer@gmail.com](mailto:jschofer@gmail.com). He now always travels with his own personal urologist who is not allowed to take vacations.)

\*The views expressed in this article are those of the author(s) and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense or the United States Government.

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for a generous donation in recognition of the support received from Robert M. McNamara, MD FAAEM, and Joseph P. Wood, MD JD FAAEM.

## A Different Perspective

*Rob Dickson, MD FAAEM FACEP*

The European Society of Emergency Medicine (EuSEM) conference in Stockholm is concluded but will leave a lasting impression on this Texas emergency physician. The meeting was held October 10-14, 2010, in Stockholm. EuSEM is a federation of 26 European nations comprised of 17,000 emergency physicians. Emergency medicine is well on the way to being recognized as a specialty throughout Europe. Given the specialty's short duration in Europe, this is a major accomplishment for our colleagues across the Atlantic.

Our host city and Swedish colleagues showed their visitors a fantastic time. Stockholm is an archipelago of 14 islands located on the south-central east coast of Sweden. It is often described as the Venice of the north because of the abundance of waterways that connect the city. This fantastic venue has an abundance of parks and outdoor green spaces as well. The meeting was well attended by emergency physicians throughout Europe and Australasia. There was good representation by U.S. physicians, including AAEM president, Howard Blumstein, and a good mix of academic and community emergency medicine physicians from throughout the United States.

The meeting started with a recap by the first president of the European Society of how far emergency medicine has come in Europe. There was an opening reception at the Stockholm city hall where we were welcomed by the mayor and enjoyed an evening in the hall where Nobel winners celebrate their prize. A gala dinner hosted by our colleagues on Tuesday night at the Nordiska Museum was a fantastic evening that included live music reliving the glory days of Abba. There were ample opportunities throughout the meeting to engage colleagues from around the globe. I have discovered through these exchanges that the practice of emergency medicine around

the world has more similarities than differences. (Yes, recalcitrant consultants and social nightmares come in a variety of languages and geographic predilections, but the challenges for EPs are very similar around the globe).

Every meeting I attend brings with it new ideas and points of view. Just a few from this meeting were hot topics in resuscitation science including data on compression-only CPR for lay rescuers and a novel device for pre-hospital hypothermia in out-of-hospital cardiac arrest. There were talks on education and research along with a request by Dr. Colin Graham, editor of the EuSEM journal for scholarly submissions. I must admit, I had not read this journal prior to this conference. During my flight home, I opened the journal, and the first article was a meta-analysis of studies regarding venous vs. arterial gases in respiratory failure. I found this article and several others from the journal useful to my practice. I get a wealth of information from my exchanges (usually over a pint or two) with colleagues from around the world that attend these meetings. I headed home with new ideas for my practice and hope to have exported a few for my European colleagues as well.

I encourage my colleagues in the states to find an international conference to attend next year. I would like to suggest the Mediterranean Emergency Medicine Conference (MEMC) September 10-14, 2011. This is a combined conference sponsored by AAEM, EuSEM and the Hellenic Society of Emergency Medicine. MEMC VI will be held on the beautiful island of Kos, in Greece. MEMC is a biennial meeting that brings together some of the best speakers from all over the world. I have attended this conference in the past and suspect the 2011 conference will not disappoint. Save the date for MEMC VI, and I look forward to seeing you in Greece.

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# Pan Pacific Emergency Medicine Conference a Reality “Hands Across the Pacific”

William Durkin, Jr., MD MBA FAAEM  
AAEM Vice President



On October 21<sup>st</sup>, a memorandum of understanding was signed between AAEM and the Korean Society of Emergency Medicine (KSEM) to hold the first Pan Pacific Emergency Medicine Conference (PEMC). The conference will be held in Seoul, South Korea, October 23-26, 2012, at the COMEX convention center. AAEM will provide speakers for one of the tracks.

AAEM board member Christopher Lee and I have been working with Dr. Seung Ho Kim, Dr. Gil Joon Suh and members of the Korean Society for over a year to arrange a joint conference. Once an agreement was reached, KSEM hosted AAEM president, Howard Blumstein, along with Dr. Lee and me to come to their annual meeting. The highlight of the meeting was a ceremony where Dr.

Blumstein and KSEM president, Dr. Seung Ho Kim, signed the memorandum of understanding on stage before the entire Korean convention.

Both organizations will be working together to make this conference a great success. It is hoped that the other Asian emergency medicine organizations will also become involved and that this conference becomes a biennial event with a different host country each time, similar to the Mediterranean Emergency Medicine Congress (MEMC).

## AAEM International Committee Report

Gary M. Gaddis, MD PhD FAAEM  
Scott G. Weiner, MD MPH FAAEM

One of the AAEM International Committee’s long-term goals is to produce a useful website that can serve as a portal for all of your international EM needs. That is, if you want to find a list of fellowships, international conferences or other resources, you need remember only one site. Now, with the gracious support of the AAEM board of directors, we have taken the first step.

**We invite you to visit our website at  
[www.aaem.org/international](http://www.aaem.org/international)**

There, you will find useful information including a list of all of the International EM fellowships available, a “Who’s Who” section listing biographies of key people involved in International EM, and useful links, including Dr. Ken Iserson’s project (REEME, a Spanish-language EM resource), and Emergency Nursing World, which maintains a detailed, up-to-date listing of EM conferences taking place internationally. You can also find all of the past *Common Sense* articles pertaining to International EM.

Another exciting development is our expansion into the Spanish-speaking world. Given the fact that Spanish is the most-spoken non-English language in the western hemisphere, we have been able to persuade the leadership of AAEM to support the development of Spanish-language content for several AAEM publications. It is our vision that Spanish-language publication of certain research-related information would improve the outreach of AAEM. The cooperation of numerous individuals has helped to enable this goal. To start, through the cooperation of Drs. David Vega and Stephen Hayden, and via the help of a team assembled by Dr. Fernando Soto, AAEM will begin publishing Spanish-language translations of the Resident Journal Reviews that appear in *Common Sense*. The English

versions will be published in *Common Sense*, and the Spanish translations will be available on the International website. We are also working towards Spanish-language translations of the abstracts of a limited number of original contributions from the *Journal of Emergency Medicine (JEM)*.

We hope that you enjoy these new features and welcome your feedback by contacting us at [info@aaem.org](mailto:info@aaem.org).

### 2011 100% ED Groups Welcome to our Newest 100% ED Groups

Bay Care Clinic LLP - WI  
Cascade Emergency Associates - WA  
Edward Hospital - IL  
Fredericksburg Emergency Medical Alliance, Inc. - VA  
OSF Saint Anthony Medical Center - IL  
Providence-Newberg (ESO) - OR  
Salinas Valley Emergency Medicine Group - CA  
Southern Colorado Emergency Medical Assoc (SCEMA) - CO  
University of Louisville - KY  
West Jefferson Emergency Physician Group - LA

To view a complete list of all 100% ED Groups please visit  
[www.aaem.org/membership/100\\_ed\\_programs.php](http://www.aaem.org/membership/100_ed_programs.php)

## Upcoming AAEM–Sponsored and Endorsed Conferences for 2011

AAEM is featuring the following upcoming sponsored and recommended conferences and activities for your consideration. For a complete listing of upcoming endorsed conferences and other meetings, please log onto <http://www.aaem.org/education/conferences.php>

### AAEM–Sponsored Conferences

Pre-conference Workshops at the 17<sup>th</sup> Annual Scientific Assembly include:

#### February 26-27, 2011

- Resuscitation for Emergency Physicians: The AAEM Course
- Radiological & Chemical Agents of Opportunity for Terrorism (AoO)™ Toxic Industrial Chemicals (TICs), Toxic Industrial Materials (TIMs) and Toxic Radiological Materials (TRMs)

#### February 27, 2011

- Advanced Airway Management – New Tricks and Devices
- Advanced Ultrasound
- High Risk Electrocardiography
- Introductory Ultrasound
- 2010 LLSA Review
- Trauma CT Interpretation
- Simulation Course – Bringing Techniques and Equipment from the Battlefield to Military and Civilian Emergency Medicine Las Vegas, NV  
[www.aaem.org](http://www.aaem.org)

#### February 28–March 2, 2011

- 17<sup>th</sup> Annual Scientific Assembly  
Orlando, FL  
[www.aaem.org](http://www.aaem.org)

#### April 6-7, 2011

- AAEM Pearls of Wisdom Oral Board Review Course  
Las Vegas, NV  
[www.aaem.org](http://www.aaem.org)

#### April 16-17, 2011

- AAEM Pearls of Wisdom Oral Board Review Course  
Chicago, Dallas, Los Angeles, Orlando, Philadelphia  
[www.aaem.org](http://www.aaem.org)

### AAEM–Recommended Conferences

#### January 9, 2011

- 4<sup>th</sup> Annual Steven Z. Miller Pediatric Emergency Medicine Course  
New York, NY  
[www.columbiacme.org](http://www.columbiacme.org)

#### January 29 – February 2, 2011

- Western States Winter Conference on Emergency Medicine  
Park City, UT  
[www.wswcem.com](http://www.wswcem.com)

#### February 3-4, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### April 5-6, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### April 8-10, 2011

- The Difficult Airway Course-Emergency™  
Las Vegas, NV  
[www.theairwaysite.com](http://www.theairwaysite.com)

#### May 5-6, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### May 13-15, 2011

- The Difficult Airway Course-Emergency™  
Boston, MA  
[www.theairwaysite.com](http://www.theairwaysite.com)

#### May 25-27, 2011

- High Risk Emergency Medicine  
San Francisco, CA  
[www.highriskem.com](http://www.highriskem.com)

#### June 2-3, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### June 10-12, 2011

- The Difficult Airway Course-Emergency™  
Chicago, IL  
[www.theairwaysite.com](http://www.theairwaysite.com)

#### July 7-8, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### August 4-5, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### September 8-9, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### September 23-25, 2011

- The Difficult Airway Course-Emergency™  
Seattle, WA  
[www.theairwaysite.com](http://www.theairwaysite.com)

#### October 6-7, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### October 28-30, 2011

- The Difficult Airway Course-Emergency™  
Atlanta, GA  
[www.theairwaysite.com](http://www.theairwaysite.com)

#### November 3-4, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

#### November 18-20, 2011

- The Difficult Airway Course-Emergency™  
Las Vegas, NV  
[www.theairwaysite.com](http://www.theairwaysite.com)

#### December 1-2, 2011

- Practical Emergency Airway Management  
Baltimore, MD  
[www.jeffline.jefferson.edu/jeffcme/airway/](http://www.jeffline.jefferson.edu/jeffcme/airway/)

Do you have an upcoming educational conference or activity you would like listed in *Common Sense* and on the AAEM website? Please contact Kate Filipiak to learn more about the AAEM endorsement approval process: [kfilipiak@aaem.org](mailto:kfilipiak@aaem.org).

All sponsored, supported and recommended conferences and activities must be approved by AAEM's ACCME Subcommittee.

## AAEM Young Physicians Section

### Patient Satisfaction – Why Should We Care?

Elizabeth Hall, MD FAAEM  
YPS Secretary/Treasurer

After years of schooling and then residency, young physicians eventually enter the work force. We start our careers, start families, build homes and begin new chapters in our lives. We work in emergency departments that are becoming increasingly busy. As we all know, more individuals are requiring the assistance of the emergency department, and some use the emergency department as their primary medical care provider. This increase in demand for services results in more crowded conditions, longer wait times, and physicians practicing hallway medicine. This all leads to greater dissatisfaction in our patients and more stress in our fellow coworkers and staff. With this increased demand for services in an already chaotic atmosphere, who has time to worry or even care about patient satisfaction?

#### Why we should and do care...

Hospitals need to show the community that they are interested in quality care, and they need to find ways to improve in order to remain competitive. Patients are our customers, and as customers, they have the right to choose where to go for their medical care. Patients are easier to serve if they feel their needs are being met. This results in happier staff and patients. Conversely, when patients' needs are not met, we often hear about it through angry letters, poor satisfaction scores or sometimes publicly in local papers. This is why patient satisfaction is extremely important to your emergency department and hospital. As young physicians, we need to continue

striving for high RVUs while maintaining high patient satisfaction scores to help with our emergency department/hospital's reputation, not to mention our own job security.

The ED is already at a disadvantage when it comes to patient satisfaction; we have long wait times, practice hallway medicine, and work in a loud and frequently chaotic atmosphere. Our patients entrust their lives to us. They come to us when they are vulnerable and in pain. They are scared and anxious and then have to deal with long wait times. Patients wait to come back to a room, wait to be seen by a physician, wait for labs to be drawn and imaging studies to be done, wait for results to come back, and wait to be admitted. This all leads to decreased satisfaction with our emergency departments.

Satisfaction trends will have peaks and valleys, but the overall trend should always be on an upswing. Making patients feel like unique individuals and keeping them updated during their long waits may also help to increase patient satisfaction. How we speak and act influences the healing process of our patients. By helping patients feel more comfortable, their anxiety lessens, and they are better able to understand what is going on, their treatment plan, and the importance of following through with their discharge instructions. We may all come to the same diagnosis for a patient, but satisfaction is also based on how the patient was treated while forming that diagnosis.

Communication is key for patient satisfaction. We must acknowledge our patient's feelings and concerns and let them know we understand and are actively paying attention to both their verbal and nonverbal language. It is not only what we say, but also how we say it. Our patients must feel that we care and have their best interest at hand. When dealing with angry and upset patients/families, there are multiple techniques that can be used to help diffuse these situations, all based on how we communicate. I recommend learning some of these techniques if you are not already aware of them.

Please, please, please keep your patient up-to-date during their visit. Let them know what you are planning on doing and why. Let them know what to expect and how long their tests and imaging studies may take. If you are transitioning care to another physician, let your patient know that you have updated the new provider so the patient is aware they are not being lost during this transition. This will help ease yet another anxiety for your patient. Ending a patient encounter on a positive note leaves a lasting impression on our patients. Remember, the more comfortable we make our patients, the more they will trust us and our treatment plan and the more they will follow through with our instructions and the more satisfied they will be.

I urge you to also remember the basics. Knock before entering the room, introduce yourself not only to the patient but also their family/friends, sit down (if possible) to be at eye level and maintain eye contact, lean forward, and keep your attention on the patient. If your patient requests a blanket or drink from you, try to get it yourself instead of relying on someone else. Remember, our behaviors sometimes do speak louder than words.

Patient satisfaction is extremely important to your emergency department and hospital. I strongly advise you to remember the basics and also learn the various communication techniques which will help you in future patient encounters. There are numerous books and courses which teach these important concepts. I ask that we all continue to strive for the best possible patient experience and satisfaction. Why? Because we should care.



## Open Mic

Sponsored by the  
Young Physicians Section

**17<sup>TH</sup> ANNUAL SCIENTIFIC ASSEMBLY**  
Tuesday, March 1, 2011  
7:30am-6:00pm

YPS Members - Limited advanced spots still available.  
Remaining spots available onsite.  
[www.ypsaaem.org](http://www.ypsaaem.org)  
[info@ypsaem.org](mailto:info@ypsaem.org)

Top two speakers will be invited to give a formal presentation at the 2012 Scientific Assembly in San Diego, CA.

For general information about Open Mic opportunities, please contact Kate Filipiak at [kfilipiak@aaem.org](mailto:kfilipiak@aaem.org) or 800-884-2236.



## RESIDENT PRESIDENT'S MESSAGE

Ryan Shanahan, MD  
AAEM/RSA President



Hello and Happy Holidays! As we near the turn of the year, AAEM's focus and energy naturally turns to the Scientific Assembly, February 28 – March 2, 2011. You should have recently received your copy of the program in the mail. I would especially turn your attention to the "Resident Track" on Tuesday. Details will be forthcoming, but I can assure you we will have some of the best in the business delivering lectures specifically devoted to residents in training. Given that the registration cost consists only of a refundable deposit, I would highly encourage you to make the trip to Orlando.

I also wanted to put in an early plug for AAEM/RSA elections next year. Elections will be held in early 2011, and I would encourage everyone to consider getting involved in this organization. This is a very word-of-mouth organization – usually those who have become involved in AAEM can point to someone who told them about the organization and did so in a passionate way. We have a reputation for being passionate. If you have not had the chance to hear someone talk about the organization, I would encourage you to look at the

"About" section of the AAEM/RSA web page and watch the debate between Drs. McNamara and Kellermann, by clicking the "AAEM/ACEP Video Debate" link on the right side of the page. It is a very informative video even if you just watch the first few minutes.

From a residency and student standpoint, you will be able to look forward to a new edition of the *AAEM/RSA Toxicology Handbook* soon. We are wrapping up the new edition now and will have it printed in the next few weeks. If you were expecting to have already received a copy, we are holding off for a little bit to allow you to get the newest and best version. As board review sessions ramp up through the country in prep for the in-training exam, AAEM will be rolling out a "Question of the Day" feature soon. You can also continue to turn towards our excellent board review book.

I will close with a wish that your holidays are merry and not completely subsumed with work. There is a perverse pleasure in our chosen specialty that on a cold holiday night, ours will be the only light in the entire house of medicine on, ready and willing to see those in need of care.

## Attention YPS and Graduating Resident Members

*CV & Cover Letter Review*  
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*Enhance your credentials.*  
*Increase your job opportunities.*

The AAEM Young Physicians Section (YPS) is excited to offer a new curriculum vitae review service to YPS members and graduating residents.

The service is complimentary to all YPS members. If you are not a YPS member, visit us at [www.ypsaaem.org](http://www.ypsaaem.org) to join and learn about the additional membership benefits.

For graduating residents, a \$25 Service Fee is required, which will be applied to your YPS dues if you join AAEM as an Associate or Full Voting Member. This offer is only valid for the year following your residency graduation.

*For more information about YPS or the CV Review service, please visit us at [www.ypsaaem.org](http://www.ypsaaem.org) or contact us at [info@ypsaaem.org](mailto:info@ypsaaem.org).*



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## RESIDENT EDITOR'S LETTER

### Maintaining Wellness in Medical Training and Beyond

Leana S. Wen, MD MSc



In my second year of medical school, I attended a reading by Dr. Abraham Verghese, a physician, writer and humanist. He had just written a book, "The Tennis Partner," that was about his friend and then-medical student who lost a slow battle to drug addiction and mental illness. "The Tennis Partner" was about how their relationship developed – how he found out about his friend's problems and then failed to

act on that knowledge. The reading was poignant because of his obvious emotional involvement and because the topic hit close to home.

How many of you know medical students, residents and doctors-in-practice who have been depressed? Who have thought about harming themselves or tried to numb their pain with alcohol and narcotics?

Studies have shown that physicians have a far higher rate of depression, substance addiction and suicide than the general population. Medical students start out with similar mental health profiles as their age-matched peers. During medical school, a quarter of medical students become clinically depressed. Ten percent entertain thoughts of suicide. Despite better access to health care, physicians-in-training seek help with lower frequency than other young professionals.

Researchers have come up with various hypotheses to explain these findings, including social isolation during training and greater tendency towards perfectionism. In a recent *New York Times* op-ed, surgeon-writer Dr. Pauline Chen discussed the problems with the "survival of the fittest" mentality that is prevalent in the medical profession. While in training, who wants to be the "weak" person who seeks help? Who wants to admit they want more support than someone else or burden others with time off or shifts to cover?

I faced this issue several months ago. My mother died in July after a long battle with cancer. She had fought it for years with surgery and aggressive chemotherapy until finally she was in remission. Then, during my internship year, we found out that the cancer was back. The last few months of her life were filled with terrible suffering. She fought despite the pain because she wanted to make sure my little 16-year old sister was OK. Finally, she agreed to enter hospice care, but she never quite made it. She died in the ICU, at age 54.

As much as my family was prepared for her death, and as much as it was welcome because it put an end to her suffering, it was a very difficult time for us. Coming back to work was much harder than I expected. Every cancer patient or terminally-ill patient reminded me of my mother and her last days. I cried after every shift. I was on an emotional rollercoaster; things would seem to be getting better, then an issue with my family, or a patient, or a patient's family, would set things off, and the rollercoaster would come crashing down.

My experience is a pretty specific example of grief and bereavement, but I think the lessons I learned are applicable to other physicians who are coping with their own challenging situations. My first lesson is to accept the support of family and friends. This may seem obvious, but I made the mistake of shutting people out and burying myself in errands and busywork just to keep occupied. Thankfully, those closest to me didn't allow me to isolate myself, and I learned that losing ourselves in our training is never a good solution. It may temporize the pain, but will ultimately serve to alienate us from those who care about us.

The second lesson is to ask for help. This could be as simple as letting your school, program or hospital know of your need for time off. In my case, I didn't tell anyone in my residency when my mother got sick. I wish I had, because I would have been able to spend more time with her in her final months. When she died, I even resisted taking time off. In retrospect, I came back to work too soon. I thought I was being strong and wanted to prove – most of all to myself – that I could do it. But the result was traumatizing to me, and I probably ended up delivering less than ideal patient care. Eventually, I did ask for help with time off, and my program director was very supportive in providing the time and space that I needed. There is really no shame in admitting that we need help, whether it's help for specific things like covering shifts, or if it's referral to a counselor or support group. Both Dr. Verghese and Dr. Chen wrote about how silence is what leads to deadly outcomes. "Physician, heal thyself" is a mantra that fosters bravado, not compassion.

The third lesson is to recognize and help address challenges that others around us are facing. Prior to my experience, I hadn't realized how prevalent depression and addiction are in our profession. "The Tennis Partner" describes a very plausible scenario that could happen to any of us. After all, if one quarter of all physicians-in-training are depressed at some point in their training, it's likely that a couple of our friends or colleagues are having problems at this moment. As physicians – indeed, as humans – we have a duty to make sure that those around us are OK.

So do your part. On a personal level, reach out to your friends. If you suspect they are in trouble, reassure them that you're there for them and that it's OK to seek help. Make use of student support services in your medical school or hospital. Start your own support groups if none exist. In my residency, I recently helped to start Emergency Medicine Reflection Rounds (EMRR) where a small group of residents meet once a month with one or two faculty members to discuss personal reflections and give advice and support for each other. EMRR has been successful so far, and the feedback we've received reinforces the importance of establishing and fostering community. Medical training is not an easy process, but we are not alone. We can each do our part to preserve humanity, promote wellness, and approach each other, and our patients, with respect and compassion.

For comments on this article, please email [LWen@partners.org](mailto:LWen@partners.org).



## Resident Journal Review: Winter 2010-2011

*Karin Chase, MD; Alena Lira, MD; Christopher Doty, MD FAAEM; and Michael C. Bond, MD FAAEM*

*This is a continuing column providing synopses of high-impact journal articles pertinent to EM residents. It is not meant to be an extensive review of the articles, nor is it wholly comprehensive of all the literature published. Rather, it is a short list of potentially useful literature important to the busy EM resident. Residents should read the articles themselves to draw their own conclusions. These papers were selected after a review of twenty-two of the most pertinent journals for emergency medicine. This edition will include articles published over a two month period, between July and August of 2010.*

### **Jones AE, Shapiro NI, Trzeciak S, et al. Lactate Clearance vs Central Venous Oxygen Saturation as Goals of Early Sepsis Therapy: A Randomized Clinical Trial. *JAMA* 2010; 303(8):739-746.**

The Surviving Sepsis Campaign has become standard practice for the treatment of septic patients in many emergency departments (EDs); however, the use of central venous oxygen saturation (ScvO<sub>2</sub>) - a quantitative tool to assess tissue oxygenation - has been somewhat controversial. This multi-center prospective, randomized, non-inferiority trial investigated whether measuring lactate clearance, as a surrogate for tissue oxygenation, was comparable to ScvO<sub>2</sub>. The outcomes measures were absolute in-hospital mortality, length of ICU and hospital stay and rate of complications.

A total of 300 patients with a confirmed or presumed infection that had two or more SIRS criteria and were hypoperfused as evidenced by either a systolic blood pressure (SBP) of less than 90 mmHg after a fluid bolus or a lactate level greater than 4 mmol/L were randomized into two groups and treated with a standard early goal directed therapy protocol. After normalization of central venous pressure and arterial blood pressure, the goals of resuscitation in the two groups were ScvO<sub>2</sub> greater than 70% or peripheral venous lactate clearance of greater than 10%, respectively. One hundred and forty seven patients in each of the groups underwent analysis. The achievement of resuscitation goals were comparable in both groups. Mean initial lactate levels were not significantly different (3.9 mmol/L and 4.2 mmol/L) between groups, and the mean lactate clearance in the lactate group two hrs after initiation of resuscitation was 40% of the initial value.

The primary outcome measure of in-hospital mortality was similar (no significant difference) between the two groups (17% in lactate group versus 23% in ScvO<sub>2</sub> group). Other outcome measures also showed no significant difference between the groups.

The authors concluded that in resuscitation of sepsis targeting lactate clearance of greater than 10% as evidence of adequate tissue oxygenation does not decrease survival rates as compared to targeting ScvO<sub>2</sub>, supporting the use of peripheral venous lactate clearance instead of the use of ScvO<sub>2</sub> measurement.

One criticism of this study is that it is underpowered. The number of enrolled patients gave a power of 71% to detect that the intervention did not increase mortality. However, the results showed a 6% decrease in mortality in the lactate group, not an increase, and a larger sample size is unlikely to change the conclusion. In our opinion, this is an important study, as it supports the elimination of the use of ScvO<sub>2</sub> catheters in sepsis management without jeopardizing patient outcomes.

### **Cross KP, Warkentine FH, Kim IK, et al. Bedside Ultrasound Diagnosis of Clavicle Fractures in the Pediatric Emergency Department. *Acad Emerg Med* 2010; 17(7):687-693.**

The use of ultrasound by the emergency medicine (EM) physician has become widespread in the diagnosis and management of a variety of medical conditions, including injuries to the musculoskeletal system. This study addressed the diagnostic utility of ultrasound in diagnosis of pediatric clavicular fractures by comparing bedside sonogram to conventional radiographs.

In a single urban ED, investigators recruited a convenience sample of pediatric patients ages 1-18 years who presented with shoulder or clavicle pain due to recent trauma. All participants were treated with analgesia and then received both an ultrasound and a radiographic evaluation. Sonographic images were reviewed by two independent ED physicians who looked for sonographic evidence of fracture such as cortical bone disruption, callus, hematoma or bone motion with respiratory effort. Both the rate of agreement with conventional radiography and inter-observer reliability were assessed.

Forty-three patients were diagnosed with clavicular fracture by conventional radiographs. Ultrasound diagnosis as assessed by a blinded ED physician who did not perform the ultrasound but reviewed the sonographic images at a later time, showed 95% sensitivity and 96% specificity (there were two false negative and two false positive ultrasound interpretations). The physician performing the bedside ultrasound had a higher rate of false positives; however, the inter-rater reliability was good to excellent (kappa 0.74). The greatest number of false positives occurred in patients where the clinical suspicion for fracture was high.

Another outcome this study assessed was whether ultrasound examination caused more pain to the patient than conventional radiographs as assessed by the FACES pain score. There was no difference between the two tests in the overall FACES pain score, but a closer examination of the data revealed that there were more patients who reported their highest level of pain while getting their conventional radiographs.

This study showed that bedside ultrasound can be used by EM physicians to accurately diagnose clavicular fractures in children without increasing their pain. This is a potentially useful application of ultrasound, as it not only can confirm the diagnosis rapidly, but it has the advantages of decreasing the radiation exposure to the child. Even though the study has apparent limitations, it has promising implications that ultrasound can be used by EM physicians to diagnose fractures.

*continued on page 21*



Resident Journal Review - continued from page 20

**Rea TD, Fahrenbruch C, Culley L, Donohoe RT, et al. CPR with Chest Compression Alone or with Rescue Breathing. *N Engl J Med* 2010;363(5):423-33.**

Recent literature has challenged the performance of conventional cardiopulmonary resuscitation (CPR) by suggesting that chest compressions alone may have improved survival outcomes than compressions paired with rescue breathing. In a multi-center randomized study of bystander-performed CPR, authors of this study compared survival and neurological outcomes of patients undergoing compressions alone versus compressions with rescue breathing.

The study included 1,941 patients in cardiac arrest who underwent CPR by bystanders instructed by an EMS dispatcher to perform either chest compressions alone or compressions with rescue breathing. The analysis of the data failed to reveal improved outcomes with chest compressions alone. However, a subgroup analysis that controlled for the cause of the arrest showed improved neurological outcomes with chest compressions alone in those who arrested due to cardiac causes.

The authors' conclusion is that more studies are required before a firm recommendation can be made. Although the results of this study as a whole did not show improved outcomes with 'compression only' CPR or CCR (cardiocerebral resuscitation), the trends in the subgroup analysis support what prior studies have shown: in a cardiopulmonary arrest originating from cardiac causes, compressions alone may improve outcomes, whereas in arrests related to respiratory causes the opposite may be true.

The key point of this study, though, is that CCR did not decrease survival. Since many bystanders are often reluctant to perform rescue breathing due to fear of communicable diseases, CCR may ultimately improve overall outcomes if more bystanders are willing to start compressions and not stand idly by, waiting for emergency medical services (EMS) to arrive.

**Bernard SA, Smith K, Cameron P, Masci K, et al. Induction of Therapeutic Hypothermia by Paramedics After Resuscitation From Out-of-Hospital Ventricular Fibrillation Cardiac Arrest: A Randomized Controlled Trial. *Circulation* 2010;122(7):737-742.**

The use of therapeutic hypothermia in cardiac arrest patients with return of spontaneous circulation who had an initial cardiac rhythm of ventricular fibrillation has shown favorable outcomes and is widely practiced. Additional data suggests that the earlier the cooling is initiated the better the outcomes will be. The authors of the current study evaluated whether initiating a therapeutic hypothermia protocol in the pre-hospital setting by EMS would improve survival and functional outcomes.

The study was a randomized controlled prospective trial conducted in Melbourne, Australia. Two hundred thirty-four patients were enrolled. Of these, 118 were assigned to the intervention group that received therapeutic cooling with 2L of intravenous (IV) lactated ringers by EMS, and 116 were assigned to the control group that had therapeutic hypothermia initiated on arrival to the hospital by similar means. Due to short transport times, most patients in the EMS group did not receive the full 2L of lactated ringers during transport, and the mean initial temperature on hospital arrival was only 0.8°C lower in the intervention group. The difference in temperature between the

two groups was completely gone after 30 minutes. Mortality and functional outcomes were similar between the two groups.

The study concluded that the EMS induced hypothermia moderately decreased body temperatures of the intervention group; however, this transient temperature difference was not sufficient to result in a change in functional outcomes. To improve the outcome, the authors suggested further studies with hypothermia initiated during CPR.

**Muller F, Christ-Crain M, Bregenzer T, Krause M, et al. Procalcitonin Levels Predict Bacteremia in Patients With Community-Acquired Pneumonia: A Prospective Cohort Trial. *Chest* 2010; 138(1):121-129.**

Guidelines for management of community acquired pneumonia (CAP) recommend obtaining blood cultures prior to administration of antibiotics. Critics of this practice argue there is a low yield of true positive cultures and an unfavorable cost to benefit ratio. Therefore, an effort has been made to identify biomarkers that would predict a positive blood culture. In recent studies, procalcitonin (PCT) has emerged as a possible biomarker for bacterial infections and their severity. In this multi-centered, prospective cohort study, the authors examined the use of PCT levels in predicting bacteremia in patients with CAP.

This study included 925 patients with radiograph-confirmed CAP. It evaluated multiple parameters for correlation with positive blood cultures, including PCT, C-reactive protein (CRP), white blood cell count (WBC), serum sodium and blood urea nitrogen (BUN) levels. The results revealed that patients with positive blood cultures had significantly higher levels of CRP, BUN and WBC counts and an almost 15 fold higher PCT level than those with negative cultures (5.8 µg/L vs. 0.4 µg/L). In a multivariate analysis of the studied parameters, PCT was the only independent predictor of positive blood cultures, whereas antibiotic pretreatment was the only independent predictor of negative cultures. The authors also showed that patients with positive blood cultures had a higher rate of transfer to the ICU, but mortality between the culture-positive and culture-negative groups was similar.

Analysis of the PCT data focused on identifying a cutoff level that maintained good sensitivity for a positive blood culture while eliminating a maximum number of unnecessary blood cultures. This analysis showed that a PCT level greater than 0.1 µg/L had a sensitivity for a positive blood culture of 99% and would be able to reduce the number of cultures by 12.6%, and a cutoff level of 0.25 µg/L would result in a 37% reduction in cultures while maintaining a sensitivity of 96%.

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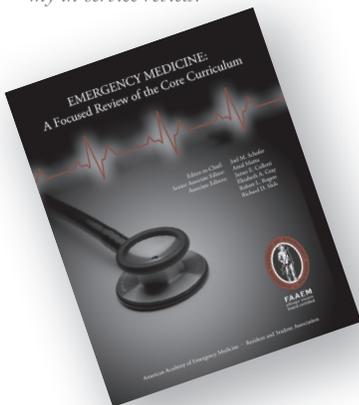
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## Look, Listen, Feel

*Caroline Pace, MD*

*Assistant Professor, Medical College of Wisconsin*

*Robert Rogers, MD*

*Resident Physician, Medical College of Wisconsin*

I remember very vividly the first time I had to tell someone that their loved one had died. I was a second year resident on a busy Saturday overnight. Typical of a Saturday overnight, we were inundated with trauma, and I remember my attending and senior resident suiting up for MVC after MVC. They were busy in the trauma bay with a bad intubation, and the charge nurse asked me to take a phone call for medical control. When I got on the phone, the paramedic spoke quickly, "Hey Doc, we're on scene with a 17-year-old female, restrained passenger of a high speed MVC with massive head and neck trauma. We are unable to intubate and cannot identify structures to perform a cric. We'll be there in 3 minutes."

About a million things ran through my head, and I did not have time to process any of it. When the ambulance rolled up, the paramedic got out, grabbed me by the arm and said, "I just couldn't call it in the field – she's too young." I walked out to the ambulance, stepped inside, and pronounced the patient dead on arrival. When the social worker asked me to talk to the girl's mother, I looked at my attending and waited for her to walk into the family room. She looked back at me and said, "There's a PEA arrest coming in, I can't do this right now. Are you comfortable giving bad news?"

We spend countless hours studying stroke, thyroid storm, and the work up of undifferentiated abdominal pain. We know how to interpret ECGs, chest X-rays and ABGs. We can manage septic shock, ruptured ectopic pregnancy and hypertensive emergencies, but no one teaches you how to tell someone that their loved one has died. Maybe more importantly, no one ever teaches how that affects you. Breaking bad news may be one of the hardest aspects of our job.

Everyone has horror stories of the family member who runs out of the room screaming, the husband who gets violent, the cousin who passes out. When it comes to giving bad news, nothing surprises me. Some people will emote profusely. The mother in the aforementioned case screamed and begged me on her hands and knees to tell her that I was lying, that her daughter was alive, that there was something else I could do. And, for every loud, emotional family member, there is a quiet, reserved parent/uncle/sibling/child. To this mother, I could only apologize.

As an attending at an academic institution, I have found that not only is giving bad news a particularly difficult skill set, it is also one that represents a unique challenge to teach. Residents are already stressed with long work hours, a new adjustment to shift work, the pressures of studying, and acquiring all of the knowledge and skills necessary to become an EM physician. Now we must try to convince them that this skill is required, cannot be read in a book, and that no matter how many times you do it, it will always be difficult. How do I teach the residents this?

In BLS, we are taught to "look, listen, feel." This same mantra applies to giving bad news. Look family members in the eye; listen to what they know and what they have to say. Understand that this

moment, this conversation, may change the trajectory of their entire lives. Susan Flanner, MSW, offers, "Putting religion aside, these are sacred moments that families will always remember." For a few minutes, death turns strangers into friends. The social worker, the family and you share this intimate event. Then, you say one final, "I'm sorry," leave the room, and for us, the death changes from a sick patient to a phone call to the medical examiner, death paperwork and a body that needs to be transported to the morgue. For us, it's over; and it has to be because that's our job. How do I teach that to a resident?

\* \* \*

I picked up the chart for room #11, a nine-year-old boy with a chief complaint of headache. Only two months into residency, I paused at the door to mentally review the "can't miss diagnoses" expecting this encounter to ultimately end with a diagnosis of "viral syndrome" or "benign headache." The room was dark; the boy was lying in bed and appeared to be sleeping. He was accompanied by his younger brother and his grandmother who had recently taken custody of the children after the mother was incarcerated. I began by questioning the grandmother about the child's symptoms but was interrupted when the boy suddenly sat up in bed, cried out, grabbed both sides of his head and vomited. There was a pit in my stomach. I staffed the patient, ordered the head CT and "moved on" to the next patient. Then came the overhead page... "Radiology on line 1 for Dr. Rogers." I chuckled to myself – I was still adjusting to hearing "doctor" before my name. I confirmed that I was taking care of "the kiddo in room 11." The radiologist, a resident herself, went on to say, "I am sorry to tell you this but he has a large cerebellar mass..." I went to my attending to discuss the results and review the CT. While coming up with our plan on how best to "break the news" I was asked if I had any experience with breaking bad news in medical school. An open-ended question – is she asking me if I want to tell the family?

During my second year of medical school, I remember the first "breaking bad news" simulator session. We had a pathology test later that week, and I kept thinking about how my time could be better spent studying. A fellow student was asked about techniques for giving bad news and reiterated the importance of eye contact and the "warning shot"...then almost as if out of nervousness blurted out, "mostly common sense stuff." This earned him the honor of being the first "volunteer" for the simulation. The student stumbled through an explanation of how the actor's wife had "passed away." The actor stood up and started screaming and cursing at the student for allowing his wife to die. The actor pressed the student with questions... "Are you even a doctor? Did you even try to save her? Why did you give up so soon?" The student sat motionless, and the class was just as shocked. The session ended and back to our pathology books we went.

In my fourth year of medical school, I did a one-month elective in palliative care and was privileged enough to work with some

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Look, Listen, Feel - continued from page 23

incredible palliative care physicians. The one thing that I heard from almost every attending was that there is no easy way to break bad news, but with training, we can make it less stressful for everyone involved. During the month we also did regular "debriefing," which stressed the importance of self-awareness and the willingness to recognize our emotions – emotions that affect our personal lives and how we are perceived by patients.

"Have you had exposure to breaking bad news in medical school?" I told my attending about my month in palliative care, and as badly as I wanted to remove myself from the situation, it was clear that I was ready to take the next step to "break the news." We rehearsed how the conversation should go, and the attending reinforced that she would be there and could take over at any time.

We entered the family room where the grandmother sat quietly on the couch. I started by explaining why the symptoms were concerning and why we ordered the CT scan. Then came the awkward transitional statement. "Unfortunately, I do have some bad news to share with you." I spoke softly and slowly. She was looking toward me, but her eyes were fixed on my chest. "The results of the CT scan show that he does in fact have a mass at the back of his brain. Although we can't be sure, it is important that you know this mass could very well be cancer." Her eyes shot down to her feet; she sat motionless and speechless for what seemed an eternity. My attending and I glanced at each other a few times, suppressing tears, anticipating how she would react. To my surprise she picked up her cell phone and dialed her husband.

Resident Journal Review - continued from page 21

The authors concluded that PCT is an accurate predictor of bacteremia and recommend that blood cultures should only be drawn if PCT levels are greater than 0.25 mg/L. This level is justified due to the low yield of blood cultures at lower levels of PCT which is offset by the time and cost associated with obtaining them.

This study was well designed, but the results might be hard to translate into clinical practice until PCT testing becomes widely available and PCT levels are reported to the clinician in a timely fashion. Patient mortality and morbidity improve when antibiotics are given early, but antibiotics are also the only independent predictor of negative blood cultures in this study. PCT levels will need to be available rapidly so there is no delay in the initiation of antibiotics for these results to translate into clinical practice.

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She was only able to say, "I'm at the hospital" before the gravity of the news finally hit her. She cried like I had never seen someone cry before. It was as if her whole body cried as she doubled over on the couch. Her husband's voice echoed back, "Calm down, honey, I can't understand you." Between the sobs and screams she found the strength to mutter, "They say he's got a tumor on his brain." All I had to offer was a box of tissues and a discussion about "what's next." We left the room, I was given feedback, the boy was admitted to the hospital, I finished my shift and went home. The next day my wife asked me how work went and I told her the story...we both cried.

\* \* \*

The two reflection pieces written above, one by an attending physician with palliative care experience and one by a first year resident with prior palliative care exposure, reinforce that even with experience, breaking bad news may be one of the most challenging aspects of our jobs. While it is important to maintain some level of "professional distance," I would argue that to be devoid of emotion when telling a mother her child is dead is not something to strive for. How then do we educate and train residents to take on this task? Unfortunately, for most programs, the answer has historically been, "We don't prepare residents for this." As a profession, it is time that we explore ways to teach residents how to "look, listen and feel."

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## MEDICAL STUDENT COUNCIL PRESIDENT'S MESSAGE A Student's Perspective on Organized Emergency Medicine

Brett Rosen  
AAEM/RSA Medical Student Council President



I hope that all of you had a chance to read the excellent article written by Dr. Ryan Shanahan, AAEM/RSA president, in the last issue of *Common Sense*. I wanted to follow his article by giving the student perspective on the professional emergency medicine organization experience. As students, the differences between the many professional organizations in emergency medicine may not impact us directly at our present level of training. Most of us who are involved are members of multiple organizations: AAEM/RSA, EMRA and/or SAEM, to name a few. The alphabet soup of emergency medicine organizations is enough to make most people confused beyond belief, so our purpose at this point should be directly related to what we do every day as a student: learning. I would encourage you to join all of the major organizations that you can, so you can get a perspective of what is going on in emergency medicine and how issues that are currently being faced will eventually affect you.

AAEM, in particular, since its founding in 1993, has always held the principle that only emergency medicine residency training is essential to board certification since the practice track closed in 1988. While not all emergency medicine organizations shared in this belief, this fundamental principle of AAEM is the foundation of why the residency training we will all eventually undertake is valued so highly. Many of us in AAEM/RSA wrote letters to the Texas Medical Board in support of the AAEM principle that only those board certified in emergency medicine by ABEM (American Board of Emergency Medicine) or AOBEM (American Osteopathic Board of Emergency Medicine) should be able to advertise themselves as "board certified" since a residency in emergency medicine is required to obtain their respective board certifications. You might ask why, as just a medical student, I wrote to a state medical board that wasn't even in my home state. The important realization I had is that when I graduate from residency, I want my patients to know that when I come in to their room as a board certified emergency physician, they will get high quality specialized care that no other path of training in emergency medicine can provide.

AAEM also stands for other fair business practices that only help to safeguard the integrity of our specialty. AAEM/RSA works to educate residents, and also students to an extent, in some business practices to watch for when signing their first contract out of residency. They fight against the lay corporate practice of medicine, and board members frequently speak at both medical schools and residency programs. In addition to all of this, we put on a fabulous Scientific Assembly which is FREE to ALL members of the organization (refundable deposit required). I encourage all of you to come to Orlando, February 27-March 2, 2011, to learn and truly see AAEM and AAEM/RSA in action!

While I am a proud member of all of the major emergency medicine organizations and am involved with each of them in some way other than just being a member, I am especially proud to be involved in AAEM/RSA. Every time I have an opportunity to do something, I feel as though I am helping my future as well as that of my current and future colleagues.

If you are reading this article, you are probably already a member of our organization. However, I would encourage you to continue your membership in addition to signing up others and educating your classmates to invest in their future. AAEM/RSA is the most affordable of all the organizations, even offering a free one-year trial membership for students. I would also encourage you to find your niche and be more than just a member by getting involved in some aspect of an organization. In AAEM/RSA, we provide a number of opportunities that will allow you to get involved as a student. After the Scientific Assembly, we will hold elections for the 2011-2012 AAEM/RSA Medical Student Council. Additionally, you can join a committee, serve as your school's site coordinator, create EMIG workshops, or write for our electronic newsletter, *Modern Resident*. Many sections of AAEM also have opportunities for student involvement, including the state chapters as well as the Uniformed Services branch of AAEM (USAAEM).

If you have any questions, comments or concerns, please do not hesitate to contact me at any time at [info@aaemrsa.org](mailto:info@aaemrsa.org). I look forward to seeing all of you at the Student Track at Scientific Assembly in Orlando. Registration is now open on the AAEM webpage [www.aaem.org](http://www.aaem.org)!



Sign up 20 or more members of your program for AAEM/RSA student membership and get recognized in *Modern Resident*, *Common Sense* and Facebook!

Contact [info@aaemrsa.org](mailto:info@aaemrsa.org) for more information and to sign up today!

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